WISCONSIN MEDICAID
PRIOR AUTHORIZATION / DRUG ATTACHMENT (PA/DGA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid and SeniorCare medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization/Drug Attachment (PA/DGA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — TYPE OF REQUEST

Element 4
Indicate the start date requested for PA or the date the prescription was filled.

Element 5
Check the appropriate box to indicate if this product has been requested previously.

SECTION III — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 6 — Drug Name
Enter the drug name.

Element 7 — Strength
Enter the strength of the drug listed in Element 6.

Element 8 — Quantity Ordered
Enter the quantity that was ordered.

Element 9 — Date Order Issued
Enter the date the order was issued.

Element 10 — Directions for Use
Enter the directions for use of the drug.

Element 11 — Daily Dose
Enter the daily dose.

Element 12 — Refills
Enter the amount of refills.

Element 13 — Name — Prescriber
Enter the name of the prescriber.

Element 14 — DEA Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

XX5555555 — Prescriber's DEA number cannot be obtained.
XX9999991 — Prescriber does not have a DEA number.

These codes must *not* be used for prescriptions for controlled substances.

Element 15
Indicate if "Brand Medically Necessary" is handwritten by the prescriber on the prescription order.

SECTION IV — CLINICAL INFORMATION
Include diagnostic, as well as clinical information, explaining the need for the product requested.

Element 16
List the recipient's condition the prescribed drug is intended to treat. Include *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes and the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if more space is required.

Element 17
Indicate source of clinical information.

Element 18
Indicate use of the product requested.

Element 19
Indicate dosage of the product requested.

Element 20 — Signature — Pharmacist or Dispensing Physician
The pharmacist / dispenser must review this information and sign this form.

Element 21 — Date Signed
Enter the month, day, and year the PA/DGA was signed (in MM/DD/YYYY format).

Element 22
Check the appropriate box indicating how the provider would like to be notified of an approved or denied PA request. Be sure to indicate a fax or telephone number if selecting either of these options.